STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155170	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE MUNCIE INC	5801 WEST BETHEL AVENUE MUNCIE, IN47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000		F0000		

This visit was for a Recertification and State Licensure Survey.

Survey dates: May 16, 17, 18, 19, and 20, 2011

Facility number: 000086
Provider number: 155170
AIM number: N/A

Survey team:
Delinda Easterly, RN, TC
Betty Retherford, RN
Ginger McNamee, RN
Karen Lewis, RN
Randy Fry, RN

Census bed type:
SNF: 55
Total: 55

Census payor type:
Medicare: 7
Other: 48
Total: 55

Stage 2 Sample: 25

These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on May 25, 2011 by Bev Faulkner, RN			
F0167 SS=C	A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on interview, the facility failed to ensure residents were aware of the location of the most recent Indiana State Department of Health survey results for 2 of 3 sampled residents interviewed for location of state survey results of the 25 residents who were included in the Stage 2 review. (Residents #27 and #45) Findings include: 1.) During an interview on 5/19/11 at 10:00 a.m. with Resident #27, the Resident Council President, the resident stated she did not know location of most recent state survey results. 2.) During an interview on 5/19/11 at 2:15 p.m., with Resident #45, the resident stated she did not know the	F0167	**Westminster Village Muncie, Inc. Plan of Correction F-167 Right to Survey Results-Readily Accessible** ***1) What corrective actions(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:*** Resident #27 has been re-educated on location of Annual Survey. Resident #45 has been discharged to Assisted Living and has been informed of location of survey results in residential area. ***2) How other Residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions(s) will be taken:*** Posting of location of survey will continue to be located on resident/family bulletin boards and locations will be reviewed in Resident Council Meetings. ***3) What measures will be put into***	06/10/2011

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	location of the most recent state survey results. **3.1-3(b)(1)**		***place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** An additional Annual Survey will be placed in the Play Court. Placement locations of surveys will be reviewed on a monthly basis in Resident Council Meetings and added to the Health Center monthly activity calendar distributed to the residents. The QA Nurse will include the question of "Where are the surveys located?" in her resident interviews/reviews. New residents will be notified of location of Annual Survey upon admission. ***4) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:*** The Director of Nursing will monitor changes on a monthly basis. The QA Nurse will report to the QA Committee quarterly the results of her resident interviews. The QA Committee will review the results quarterly and modify the audit system after three (3) quarters (nine (9) months) as the information warrants. ***5) All components of the systematic adjustments for notification of changes will be implemented by*** June 10, 2011.	

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F0241 SS=D	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review and interview, the facility failed to ensure a resident's dignity was maintained regarding to her wishes not being honored related to her not wanting personal alarms in place to her bed and wheelchair for 1 of 1 resident reviewed who met the criteria in a Stage 2 sample of 25 . (Resident #55) Findings include: **The clinical record for Resident #55 was reviewed on 5/17/11 at 10:00 a.m.** **Resident #55's current diagnoses included, but were not limited to chronic lower back pain, depression and anxiety.** **A quarterly Minimum Data Set assessment, dated 3/8/11, indicated Resident #55 had no cognitive impairment and required limited staff assistance of 1 for all activities of daily living.** **A health care plan, dated 12/25/10,**	F0241	**Westminster Village Muncie, Inc. Plan of Correction F- 241 Dignity and Respect of Individuality** ***1) What corrective actions(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:*** Resident #55 and her family member have been counseled again on her risk for falls and the detrimental affects of injury from falls. The resident wishes to exercise her right to fall. The alarms have been removed per her request. ***2) How other Residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions(s) will be taken:*** All residents in the facility with alarms in use have been audited by the MDS Nurses and reviewed by the Fall Committee to ensure resident dignity is maintained per their wishes. This audit will be presented to the QA Committee. ***3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** In-services will occur for all nurses by June 10, 2011.	06/10/2011

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	indicated Resident #55 had a problem listed as, resident is at risk for falls. An intervention for this problem was to have bed and wheelchair alarms in place at all times. **Clinical record review on 5/17/11 at 10:00 a.m., indicated Resident #55 had a history of falls. The nursing staff initiated the use of personal alarms on the resident's bed and wheelchair as a nursing measure on 1/10/11.** **During observation on the following dates and times Resident #55 had an alarm in place,** **A. 5/16/11 at 10:00 a.m., resident was in her bed.** **B. 5/16/11 at 12:30 p.m., resident was up in her wheelchair.** **C. 5/17/11 at 8:30 a.m., resident was up in her wheelchair.** **D. 5/18/11 at 9:15 a.m., resident was up in her wheelchair.** **E. 5/18/11 at 1:30 p.m., resident was up in her wheelchair.**		In-services will include: fall risk assessment, dignity and reporting to Nurse Managers if a resident has requested to have alarms removed. (See Attachment). Any resident requesting that alarms be removed will be addressed through members of the Fall Committee. ***4) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:*** MDS Nurses will audit eight (8) residents utilizing alarms on a monthly basis for nine (9) months to ensure this alleged deficient practice does not recur. Audit results will be reviewed by the Fall Committee on a monthly basis. The QA Committee will review the results monthly and modify the audit system after nine (9) months as the information warrants. ***5) All components of the systematic adjustments for notification of changes will be implemented by*** June 10, 2011.	

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	During an interview with Resident #55 on 5/16/11 at 3:30 p.m., she indicated the facility staff did not treat her with dignity. The resident indicated she did not like the alarms. She indicated the alarms were "very annoying" and "I don't want them on here." The resident indicated the alarms go off "all the time". The resident then stood and the chair alarm sounded and the resident stated "See!" The resident indicated she had talked to "everyone" about the alarms and no one would listen. **During an interview with the Social Services #12 on 5/19/11 at 1:05 p.m., she indicated she was aware Resident #55 had a concern with the alarms being in place to her bed and wheelchair. She indicated herself and the resident had many conversations related to the alarms. She (Resident #55) doesn't think she needs them and she doesn't like them. The social services director had no information to provide related to any interventions other than the alarms which had been attempted to prevent possible falls for the resident.**			

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	3.1-3(t)			
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review, observation and interview, the facility failed to ensure the nursing staff developed a comprehensive health care plan in regards to a pending	F0279	**Westminster Village Muncie, Inc. Plan of Correction F- 279 Develop Comprehensive Care Plans** ***1) What corrective actions(s) will be accomplished***	06/10/2011

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	home discharge and/or the development of a pressure sore for 2 of 25 sampled residents reviewed for care plan development from the Stage 2 sample of 25. (Resident #45 and #32) Findings include:		***for those Residents found to have been affected by the alleged deficient practice:*** Care Plan of Resident #32 has been reviewed and updated to reflect that the resident's current skin care needs are being met. Care Plan of resident #45 has been reviewed and updated. Resident has been discharged to licensed residential. ***2) How other Residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions(s) will be taken:*** All resident's Care Plans have been reviewed by MDS Nurses or Unit Managers. The goals and approaches have been updated if necessary. Dates have also been corrected if not accurate. The MDS Nurse has been in-serviced about updating Care Plans with current dates. ***3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** In-services will occur for all Nurses by June 10, 2011. In-services will include assessment and documentation of pressure areas, importance of Nursing and Social Services to participate, make discharge plans, and update the Care Plans acordingly. (See Attached). ***4) How the corrective action(s) will be monitored to ensure the***	

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	1.) Observations of Resident #32 on 5/18/11 at 10:55 A.M. and 2:50 P.M., indicated the resident was lying in bed with bilateral heel protectors in place. An observation of the treatment for this resident's right heel pressure ulcer on 5/18/11 at 3:30 P.M., indicated the resident had a 0.5 cm diameter scabbed area on right heel. The skin surrounding the scabbed area was clear, intact, and normal color. The Admission MDS (Minimum Data Set) assessment, dated 12/23/10, indicated the resident did not have a pressure ulcer. The nursing notes for Resident #32		***alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:*** Unit Managers will randomly audit ten (10) Care Plans per month for completeness and accuracy and report audit to QA Committee monthly for nine (9) months. The QA Committee will review the results monthly and modify the audit system after nine (9) months as the information warrants. ***5) All components of the systematic adjustments for notification of changes will be implemented by*** June 10, 2011.	

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	included the following: "1/21/11 at 3:30 PM: New order received from PT for resident to have sheepskin heel protectors on bilateral feet while in bed d/t (due to) softening of bilateral heels." "2/12/11 at 8:45 PM: Linen cradle and sheepskin heel protectors in place." "2/14/11 10:47 AM: ...Resident left facility at 10:53 AM in transport to (local hospital)..." "2/19/11 at 5 PM: Resident arrived at facility at 3:40 PM from (local hospital)..." The nursing admission history and physical, dated 2/19/11, included a check mark for right heel "pressure points/alteration in skin assessment." There was no additional documentation the right heel area was assessed. Additional nursing notes included: "2/20/11 at 8:00 PM: Late entry for 2/19/11 at 9:00 PM...skin warm dry and intact..." "2/23/11 8:45 PM...linen cradle and waffle boots in place..."			

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	The nursing care plan, dated 12/11/10, for Resident #32 included the following: "Problem: (Resident) is at risk for skin breakdown related to bowel and bladder incontinence, impaired mobility/debility, extensive assist with bed mobility, Braden Score=12; high risk for PU (pressure ulcer), poor nutritional intake, has stage two PU (pressure ulcer) scabbed over to right heel. Resident is on hospice care, and has cognitive deficit. Goal: (resident) will be free from skin breakdown through next review. Approach: Assess skin condition frequently. Notify Physician of s/sx (signs and symptoms) of breakdown. Good peri-care after incontinence episodes. Encourage to turn at frequent intervals. 1/2 side rails up to assist with bed mobility. Encourage 100% consumption of meals. Use disposable briefs/pads and assist (resident) as needed to keep dry. Diet as ordered (includes consistency/texture and thickening of liquids). Monitor for compliance and acceptance. Notify Physician as needed, modification as necessary.			

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	Special cushion in wheel chair. Alternating air mattress on bed. 1/21/11: Sheepskin heel protectors to bilateral feet in bed (sore on heel). 1/21/11: Linen cradle over feet in bed as (resident) tolerates...coordinate care for resident between hospice, family, resident, and facility staff..." 2/7/11: Donut heel protectors to bilateral ankles in bed. 4/8/11: Granulex spray to bilateral heels TID (three times daily). There were no specific measurable goals for prevention of pressure sores. There were no specific interventions to prevent skin breakdown to the heels prior to 1/21/11. An interview with the Unit Manager on 5/19/11 at 9:20 A.M., indicated the care plan was inaccurate, and the pressure ulcer was found when the resident returned from the hospital on 2/19/11. The Unit Manager said the problem documentation from 2/19/11 was added to the original care plan problem, dated 12/11/10, and the new date did not transfer. 2.) Resident #45's clinical record was reviewed on 5/18/11 at 8:52 a.m. During an 5/16/11 at 3:30 p.m., interview with Resident #45, she			

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	indicated that she would be going to an apartment this month. Clinical record review lacked any health care plan related to discharge planning for Resident #45. During an 5/19/11 at 2:41 p.m., interview with Social Services #12, additional information was requested related to the development of a comprehensive plan of care for Resident #45 related to a pending discharge. The facility failed to provide any nursing comprehensive health care plan related to discharge planning for Resident #45 as of exit on 5/20/11. 3.) Review of the current undated facility policy, titled, "Resident Care Plan", provided by the Administrator on 5/20/11 at 1:00 p.m., indicated the following, "Basic Responsibility: All resident care care providers.... Purpose: The results of the comprehensive assessment are used to develop, review and revise the comprehensive plan of care... Concerns and Problems,			

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	1. The specific problem as well as the underlying cause should be listed... Resident goals, A. List a measurable, reasonable goal for each problem identified... Approach/Plan A. List all care to be provided for the problem listed. The care must be necessary and appropriate to accomplish the goal stated. B. Coordinated all care to be provided to the resident for the most effective, efficient utilization of resources. C. Communicate vial information to all staff providing direct resident care... Discharge - Goal The discharge planning goal is determined by the resident's rehabilitation potential and the resident's wishes and ability to return to prior living arrangements. The long term goal should be related to the discharge planning goal...." 3.1-35(a)			

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F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review, observation, and interview, the facility failed to ensure all fluid intake was recorded and monitored on a daily basis for 1 of 1 sampled resident with physician's orders for fluid restriction of the 25 residents who were included in the Stage 2 review. (Resident #85) Findings include: 1.) The clinical record for Resident #85 was reviewed on 5/18/11 at 10:00 a.m. Diagnoses for Resident #85 included, but were not limited to, chronic kidney disease stage 4 and acute renal failure. The clinical record indicated Resident #85 went out of the facility 3 times weekly for outpatient dialysis treatment. A physician's order, dated 4/19/11,	F0309	**Westminster Village Muncie, Inc. Plan of Correction F- 309 Provide Care/Services for Highest Well Being** ***1) What corrective actions(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:*** The fluid restriction order has been reviewed for resident #85. A daily monitoring system including fluid intake totals have been initiated and will be monitored daily by Nursing staff. ***2) How other Residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions(s) will be taken:*** Any resident on fluid restriction has the potential to be affected by the alleged deficient practice. However, currently no other residents in the Health Center have a fluid restriction at this time. ***3) What measures will be put into place or what systemic changes will be***	06/10/2011

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WESTMINSTER VILLAGE MUNCIE INC	5801 WEST BETHEL AVENUE MUNCIE, IN47304

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	indicated Resident #85 had a fluid restriction of 1200 milliliters (ml) in a 24 hour period. A health care plan problem, dated 4/18/11, indicated Resident #85 had end stage renal disease and new onset dialysis treatment. The health care plan problem indicated the resident had a daily 1200 milliliter (ml) fluid restriction. A health care plan problem, dated 4/18/11, indicated the resident had congestive heart failure and the staff were to monitor the resident's intake and output and maintain the fluid restriction. The clinical record lacked any fluid consumption records with daily intake amounts for the month of May 2011 to determine compliance with the 1200 ml fluid restriction. During an interview with Unit Manager #8 on 5/19/11 at 11:20 a.m. ,she indicated she did not know of any current method where a daily running total of Resident #85's fluid intake was recorded. She indicated the CNA's entered fluid intake recorded at meals into the kiosk (computer input screen) on each shift, but the there was no total for all fluids consumed by the resident or provided by the nursing staff during a 24 hour period		***made to ensure that the alleged deficient practice does not recur:*** The fluid restriction policy was reviewed and updated to include 24 hour totals of fluid intake for residents on fluid restriction. Nursing will monitor daily by pulling “I & O By Day” records from the kiosk. These will be placed in the Nurse’s note section of the chart. The Unit Manager will review on a weekly basis. An in-service on Physician ordered fluid restriction has been scheduled on or before June 10, 2011 for all Nurses. (See Attached). ***4) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:*** The Nurse Managers will audit weekly per Fluid Restriction Policy and present results to the QA Committee for review monthly for nine (9) months. The QA Committee will review the results monthly and modify the audit system after nine (9) months as the information warrants. ***5) All components of the systematic adjustments for notification of changes will be implemented by*** June 10, 2011.	

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	available for review. During a review of the kiosk information for Resident #85's intake from 5/1/11 through 5/16/11, provided by Unit Manager #8 on 5/19/11 at 3:40 p.m., the following fluid consumed during the resident's meals was recorded as noted below: 5/1/11- 750 ml 5/2/11 - 563 ml 5/3/11 - no fluid intake recorded 5/4/11 - 803 ml 5/5/11 - 120 ml 5/6/11 - 873 ml 5/711 - 442 ml 5/8/11 - 663 ml 5/9/11 - 640 ml 5/10/11 - 450 ml 5/11/11 - 682 ml 5/12/11 - 300 ml 5/13/11 - 120 ml 5/14/11 - no fluid intake recorded 5/15/11 - 421 ml 5/16/11 - 402 ml The listed totals lacked any information related to the amount given by the nurses during medication pass or the amount consumed by the resident in her room other than at meal times. During a medication pass observation			

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	on 5/16/11 at 2:40 p.m., Resident #85 was given a nebulizer treatment. The resident had a can of a nutritional supplement in her room which she kept on ice to keep cold. The resident indicated she liked to sip it over the course of the day. No intake consumption sheet was noted at the bedside. During an interview on 5/19/11 at 3:28 p.m., Unit Manager #8 indicated there was currently no method in place to determine Resident #85's total fluid consumption on a 24 hour basis to determine if the 1200 ml fluid restriction was being met. 2.) Review of the current, undated facility policy titled "Intake and Output Measurement", provided by the Assistant Administrator on 5/20/11 at 8:30 a.m., included, but was not limited to, the following: "Basic Responsibility: Licensed Nurse and Nursing Assistant ...Purpose To maintain an accurate measurement of the resident's intake and output to assess fluid balance. ...General Guidelines for Assessment			

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	may include, but are not limited to: ...Dehydration and fluid balance ...Dietary of fluid restrictions.... ...The following residents require measurement and general documentation guidelines of intake and output every 38 hours , including a 24-hour total and weekly evaluation: ...5. All residents with an order for fluid restriction or encouragement. (Intake required.)... ...Procedure: 1. Enter resident's name and/or identification on the daily intake and output record and post per facility policy. 2. Measure and record all liquids ingested. ...7. The intake and output are to be totaled and recorded on the permanent intake and output record every shift. 8. Intake and output are totaled every twenty-four hours. 9. The intake and output is to be evaluated weekly to determine			

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	adequacy. If not adequate or if output is more than intake, the physician is to be notified and corrective action taken...." **3.1-37(a)**			
F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review, and interview, the facility failed to follow their policy and procedure for accurately and thoroughly assessing and treating a pressure ulcer for 1 of 3 residents in a sample of 6 who met the criteria for pressure ulcers in a Stage 2 sample of 25. (#32) Findings include: Observations of Resident #32 on 5/18/11 at 10:55 A.M. and 2:50 P.M., indicated the resident was lying in bed with bilateral heel protectors in place. An observation of the treatment for	F0314	**Westminster Village Muncie, Inc. Plan of Correction F- 314 Treatment/Services to Prevent/Heal Pressure Sores** ***1) What corrective actions(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:*** Skin assessments were completed on 5/20/2011, 5/27/2011 and 6/3/2011 for Resident #32 per facility policy. Facility was aware of missing assessments before the survey and had taken appropriate action with the staff member involved to resolve the issue. ***2) How other Residents having the potential to be affected by the same alleged deficient practice will be***	06/10/2011

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	this resident's right heel pressure ulcer on 5/18/11 at 3:30 P.M., indicated the resident had a 0.5 cm diameter scabbed area on right heel. The skin surrounding the scabbed area was clear, intact, and normal color. Review of the undated current facility policy and procedure for Pressure Ulcer Care and Prevention provided by the Unit Manager on 5/19/11 at 10:50 A.M., included, but was not limited to the following: "...General Documentation Guidelines...If a pressure ulcer is present, the licensed nurse is responsible to record condition of the skin, including stage, size, site, depth, color, drainage and odor as well as the treatment provided..." Review of the clinical record for Resident #32 on 5/18/11 at 9:30 A.M., indicated the resident was admitted to the facility on 12/11/10. The Admission MDS (Minimum Data Set) assessment, dated 12/23/10, indicated the resident did not have a pressure ulcer. The nursing notes for Resident #32 included the following:		***identified and what corrective actions(s) will be taken:*** The documentation of all residents with pressure areas has been reviewed for accuracy and timeliness and was found to be in compliance at this time. ***3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** A pressure ulcer in-service has been assigned on SilverChair for all Nurses to be completed in June. In-services will occur for all Nurses by June 10, 2011 and will include the importance of pressure ulcer staging and weekly assessments. (See Attached). A CareTracker message to all CNA's concerning the importance of daily documentation of placement of pressure preventative devices has been posted. ***4) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:*** RN Managers and QA Nurse will review pressure ulcer assessment documentation weekly for three (3) months then two (2) times a month for six (6) months. The results of the audits will be reviewed in the Skin Committee and presented at the monthly QA Committee meeting. The QA Committee will review the results monthly and modify the audit system after nine	

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	"1/21/11 at 3:30 PM: New order received from PT for resident to have sheepskin heel protectors on bilateral feet while in bed d/t (due to) softening of bilateral heels." "2/12/11 at 8:45 PM: Linen cradle and sheepskin heel protectors in place." "2/14/11 10:47 AM: ...Resident left facility at 10:53 A.M. in transport to (local hospital)..." "2/19/11 at 5 PM: Resident arrived at facility at 3:40 P.M. from (local hospital)..." The nursing admission history and physical, dated 2/19/11, included a check mark for right heel "pressure points/alteration in skin assessment." There was no additional documentation the right heel area was assessed. Additional nursing notes included: "2/20/11 at 8:00 PM: Late entry for 2/19/11 at 9:00 PM...skin warm dry and intact..." "2/23/11 8:45 PM...linen cradle and waffle boots in place..." The nursing care plan, dated		(9) months as the information warrants. ***5) All components of the systematic adjustments for notification of changes will be implemented by*** June 10, 2011.	

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	12/11/10, for Resident #32 included the following: "Problem: (Resident) is at risk for skin breakdown related to bowel and bladder incontinence, impaired mobility/debility, extensive assist with bed mobility, Braden Score=12; high risk for PU (pressure ulcer), poor nutritional intake, has stage two PU (pressure ulcer) scabbed over to right heel. Resident is on hospice care, and has cognitive deficit. Goal: (resident) will be free from skin breakdown through next review. Approach: Assess skin condition frequently. Notify Physician of s/sx (signs and symptoms) of breakdown. Good peri-care after incontinence episodes. Encourage to turn at frequent intervals. 1/2 side rails up to assist with bed mobility. Encourage 100% consumption of meals. Use disposable briefs/pads and assist (resident) as needed to keep dry. Diet as ordered (includes consistency/texture and thickening of liquids). Monitor for compliance and acceptance. Notify Physician as needed, modification as necessary. Special cushion in wheel chair. Alternating air mattress on bed.			

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	1/21/11: Sheepskin heel protectors to bilateral feet in bed (sore on heel). 1/21/11: Linen cradle over feet in bed as (resident) tolerates...coordinate care for resident between hospice, family, resident, and facility staff..." 2/7/11: Donut heel protectors to bilateral ankles in bed. 4/8/11: Granulex spray to bilateral heels TID (three times daily). There were no specific measurable goals for prevention of pressure sores. There were no specific interventions to prevent skin breakdown to the heels prior to 1/21/11. The skin protectants/precautions detail report had no documentation the heel protectors/air boots were in place for the following days: April: 11, 13, 14, 15, 18, 19, 23, 25, 28, and 29, 2011. May 4, 7, 9, 10, 13, 14, and 17, 2011. An interview with CNA #1 on 5/19/11 at 11:20 A.M., indicated she was not sure why the air boots were not documented on this report, but said "we just forgot I guess." The pressure ulcer assessment form included the following assessments for Resident #32:			

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	"2/19/11: 0.1 cm depth." There was no documentation of size, color, odor, drainage, stage, or the surrounding skin on the 2/19/11 assessment. "2/28/11: rt (right) heel 0.9 by 0.8 cm, depth 0.1)." There was no additional documentation. 3/4/11: 0.9 by 0.8, dry brown scab with sloughing edges. 3/11/11: 0.9 by 0.7, depth 0, drainage 0, scab, dry peeling. 3/18/11: 1 by 1 cm, depth 0, drainage 0, scab. 4/1/11: 0.5 by 0.5 cm, depth 0, drainage 0, scab. 4/8/11: 0.5 by 0.2 cm, depth 0, drainage 0, scab. 4/15/11: 0.4 by 0.2 cm, depth 0?, drainage 0, scab, slight improve [sic]. 5/6/11: 0.4 by 0.2 depth ?, drainage 0, scab-same. 5/13/11: still open, 0.4 by 0.3 with scab." There was no documentation the right heel wound was assessed from 2/19/11 through 2/28/11, and from 4/15/11 through 5/6/11. An interview with LPN #2 on 5/16/11 at 2:00 P.M., indicated the skin assessment form should have coded the right heel wound as unstageable due to the scabbed center documented on 3/4/11.			

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	An interview with the Unit Manager on 5/19/11 at 9:20 A.M., indicated the care plan was inaccurate, and the pressure ulcer was found when the resident returned from the hospital on 2/19/11. The Unit Manager indicated the problem documentation from 2/19/11 was added to the original care plan problem, dated 12/11/10, and the new date did not transfer. The Unit Manager indicated there was no specific wound nurse in the facility, but one nurse did the wound measurements every Friday. She indicated there was no additional documentation the air boots were in place daily in April and May 2011, and no additional documentation the wound was assessed at least weekly. 3.1-40(a)(1)			

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F0325 SS=D	Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview, the facility failed to ensure residents with significant weight loss were monitored and interventions were added to prevent further weight loss for 2 of 4 residents reviewed for weight loss in a sample of 10 who met the criteria for weight loss in a Stage 2 sample of 25 (Resident #'S 55 and 45) **Findings include:** **1.) Review of the current undated facility policy, titled "Weight / Height Management Policy" provided by the Administrator on 5/20/11 at 12:50 p.m. indicated the following,** **"Policy: Significant weight changes, as defined below, will be care planned and individualized interventions will be initiated and monitored for desired outcome.**	F0325	**Westminster Village Muncie, Inc. Plan of Correction F- 325 Maintain Nutrition Status Unavoidable** ***1) What corrective actions(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:*** Nutritional status was reviewed with Resident #55. Resident agreed to Daily Supplement in addition to HS snack. Physician order was obtained. Resident #45 was discharged to licensed residential. ***2) How other Residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions(s) will be taken:*** All residents requiring weight monitoring will be identified as potentially at risk for the alleged deficient practice stated above. Nutritional Services and Nursing Administration have reviewed and revised the policies and procedures titled, “Weight/Height Management” and “Tracking	06/10/2011

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	Significant Change: **Gain or loss of 5% or more in 1 month nrsg [nursing staff] to report to MD [medical doctor]...** **Objectives:** **To obtain accurate height and weight of each resident** **To maintain control of weight changes** **To assess nutrition and hydration status of resident..."** **2.) Review of the current undated facility policy titled, "Tracking Weight Changes", provided by the Administrator on 5/20/11 at 12:50 p.m. indicated the following,** **"Policy:** **Weights will be documented for all residents, for the purpose of assessing significant weight changes.** **Procedure:** **1. The facility is responsible for**		Weight Changes". In-services related to the revised policies and procedures will occur for Dietary Staff involved in implementation and all Nurses by June 10, 2011. (See Attached Documents). ***3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** Updates for policies and procedures include: § Weekly weights properly documented in kiosk for the first four (4) weeks upon admission and thereafter only as ordered by Physician or deemed necessary by nursing judgment;§ Nutritional services will notify Unit Managers or designee of resident weights changes and or re-weighs;§ Physician will be notified of resident weight loss or gain of 5% or more in one (1) month or 10% or more in six (6) months;§ Interventions will be reflected in resident's chart and/or Care Plan as appropriate to address overall nutritional need based on information obtained. ***4) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:*** Registered Diet Technicians will perform a weekly monitoring of all resident weights. The results will be reported monthly to the QA Committee by the Registered Diet	

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	obtaining correct weight upon admission, re-admission, monthly and per MD [medical doctor] order and for keeping accurate record... **2. A copy of weight records will be obtained from the kiosk [computer tracking system], nursing staff and/or chart and reviewed by the appropriate professional each month(unit supervisor, RD [registered dietician], DTR [dietary] or other appropriate person)... A copy of all significant weight losses and gains will be given to the unit supervisor and /or unit nurse...** **3. All residents with significant weight changes will be re-weighed to assure accuracy of the weight prior to reporting this to the staff, physician or family...** **4. The RD/DTR will review and document on all significant weight changes, with appropriate referral to the physician. The RD/DT/Nursing will review all significant weight losses and referrals and take action as necessary.** **5. The nursing staff/supervisor will**		Technicians. The QA Committee will review the results monthly for nine (9) months. At that time, frequency of reporting will be determined. ***5) All components of the systematic adjustments for notification of changes will be implemented by*** June 10, 2011.	

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	be notified of any individual with an unplanned significant weight change of 5% or more in 1 month and are to report to the MD. 3). The clinical record for Resident #55 was reviewed on 5/17/11 at 10:00 a.m. Resident #55's current diagnoses included, but were not limited to, pain, depression and anxiety. A health care plan for Resident #55, dated 12/20/10, indicated the resident had a problem listed as, resident is nutritionally at risk related to a diagnosis of diabetes wit a therapeutic diet. The goal was, the resident will be compliant with therapeutic diet and continue with intake of 65-75% and maintain weight. Interventions for this problem were, diet as ordered, monitor/record fluid and oral intake, monitor weight regularly, and encourage fluid and oral intake. Review of a "Quarterly Nutritional Assessment", dated 3/9/11, indicated Resident #55's current weight was 120.4. The resident's usual weight was 131.6. Weight change down 5.8			

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	pounds in 1 month 4 %, down 10.7 pounds, 8% for 3 months, significant change with no changes to be made in plan of care. Review of a print off from the computer system kiosk titled , "Weight Change Report" for Resident #55 indicated the following weights. 12/27/10 weight 140 1/4/11 weight 125.20 2/1/11 weight 126.20 3/1/11 weight 120.40 During an interview on 5/18/11 at 10:40 a.m., with dietary staff #13 (who had signed the above "Quarterly Nutritional Assessment") she indicated the facility did not start any supplements or add any nutritional interventions for Resident #55 when the significant weight loss was noted. She indicated nothing was documented as to any conversations with the staff, physician and or the resident, related to any dietary changes noted after the significant weight loss. She indicated the resident's weights had now stabilized. During an interview with CNA #14 on 5/18/11 at 1:55 p.m., she indicated CNAs are given a list every morning of any resident who need weighed.			

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	She indicated after the resident is weighed the CNA then enters the weight in the computer. During an interview LPN #14 on 5/18/11 2:10 p.m., she indicated CNAs weigh residents and enter information into kiosk. She further indicated the dietary department would send the units a notice if any resident had significant weight loss. During an interview with LPN #9 on 1/19/11 at 7:40 a.m., she indicated CNAs weigh residents and record in kiosk. She indicated the dietary department would let them know if a resident had significant weight loss. She indicated after the nursing staff were aware of the weight loss they would follow thru and call the physician. She indicated the nursing staff could print the weights off from the computer kiosk if they needed to. She further indicated the nursing staff usually wait for the dietary department to let them know if a resident has any weight loss. 4.) Resident #45's clinical record was reviewed on 5/18/11 at 9:33 a.m. Diagnoses for Resident #45 included,			

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	but were not limited to, hypertension, diabetes mellitus, and anxiety disorder. The resident's weights were as follows: Date: 02/14/2011; Weight: 170. Date: 03/01/2011; Weight: 161. Date: 03/17/2011; Weight: 168. Date: 04/05/2011; Weight: 162. The resident lost 5.29% from the first weight to the second weight. The resident lost 1.18% from the first weight to the third weight. The resident lost 4.71% from the first weight to the fourth weight. A current health care plan problem indicated Resident #45 was at a nutritional risk as evidence by intake less than 75% of meals, needs limited assistance, and indigestion with hiatal hernia repair. Approaches included, but were not limited to, monitor/record fluid and PO intake, monitor/record weight regularly, and as ordered. Notify physician if weight loss 5% in one month, 10% in 180 days, or below identified target weight. Encourage fluid and PO intake. A readmission Nutritional assessment, dated 4/5/11, indicated the resident's weight was up 7 pounds or 4% in one month, and had			

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	decreased 2.4 lbs in three months. During a 5/18/11 at 10:45 a.m., interview with Dietary Technician # 13, she indicated assessments are completed at 5, 14, 30, 60, 90 days, and quarterly. Dietary Technician # 13 stated she does not assess residents between ordered weights unless directed by nursing. During a 5/18/11 at 1:34 p.m., interview with LPN # 2, she indicated monthly weights are printed out of Care Tracker (computer system). Dietary staff reviews and informs nursing staff of any significant weight changes. Nursing then notifies physician and obtains any new orders. If nursing is concerned about resident weight changes, they can inform dietary at any time (does not have to wait until monthly reports). During a 5/20/11 at 10:03 a.m., interview with Dietary Technician # 13, she indicated 165 lbs was used as Resident #45's usual body weight. Dietary Technician # 13 prints out monthly reports to review weights (more often for more frequent weights-weekly, etc). Nursing staff enters weights on 1st Tuesday of month. Dietary Technician # 13 prints reports as soon as all weights are			

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	recorded. Dietary Technician # 13 will ask staff for re-weights if questionable weight increase or decrease. Nursing staff are given a monthly report with weight increases/decreases highlighted. The nursing staff are responsible to contact physician regarding significant weight changes. 3.1-46(a)(1)			
F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			

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	Based on record review, observation, and interview, the facility failed to ensure increased dosage of anti-anxiety medication was warranted, failed to document symptoms related to resident request for PRN anti-anxiety medications, and failed to ensure a resident's pulse was assessed prior to administration of a high blood pressure medication. This affected 3 of 10 residents reviewed in the sample of 11 who met the criteria for review of unnecessary medications. (Resident #36, #20, and #34) Findings include: 1.) The clinical record for Resident #36 was reviewed on 5/18/11 at 10:25 a.m. Diagnoses for Resident #36 included, but were not limited to, congestive heart failure, depressive disorder, and anxiety state. A Significant Change Minimum Data Set Assessment (MDS), dated 4/9/11, indicated the resident had problems with orientation and recall. The MDS lacked documentation of the resident having any problems with behaviors. Resident #36 had a current	F0329	**Westminster Village Muncie, Inc. Plan of Correction F- 329 Drug Regime is Free From Unnecessary Drugs** ***1) What corrective actions(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:*** PRN Ativan has been discontinued for non use for Resident #36. Resident is on Hospice and is terminal. Resident #20 was interviewed by MDS Nurse. She verbalized specific signs of her anxiety. Care Plan has been updated. Resident has life long practice of addressing her anxiety with medication use, as ordered by her Physician. Resident #34 Vitals Detail Report was reviewed. There were 30 entries for pulse recorded in kiosk. Staff has been educated/in-serviced as to the importance of documenting pulse in the kiosk and on the MARS to meet the documentation system requirements. It should be noted that no detrimental affect occurred with the resident. ***2) How other Residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions(s) will be taken:*** All resident's MARS have been reviewed. All diagnoses are appropriate for PRN anxiety medications. We have included in the Nursing Meeting an	06/10/2011

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	physician's order for Ativan (an antianxiety medication) 0.5 mg (milligrams) tab 1 TID (three times daily) for anxiety. The resident also had an order for an extra dose of Ativan 0.5 mg one tab once daily as needed for anxiety. The original date of these orders was 3/7/11. These Ativan orders were an increase from a previous routine order of Ativan 0.25 mg tab 1 TID for anxiety. A nursing note, dated 3/7/11 at 5:00 p.m., indicated the physician had been contacted at the daughter's request because the resident was "crying out and coughing.". The nursing notes lacked any information related to any assessment of the resident for other causes of the "crying out." The nursing notes, dated 3/2/11 through 3/7/11, indicated the resident was receiving treatment for pneumonia and some occasional coughing was noted. The nursing notes lacked any documentation of increased anxiety being noted by the nursing staff or complaints of anxiety relayed by the resident. The clinical record lacked any other diagnosis for the use of the Ativan. The medication records for March,		emphasis placed upon documented signs and symptoms of anxiety. MARS have also been reviewed of residents with set perimeters of vitals before medication administration. Staff education has been initiated. ***3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** All Nurses in-serviced by June 10, 2011. In-service will include signs/symptoms of anxiety, interventions prior to medication administration, documentation of effectiveness of medication and proper documentation of vital signs before medication administration. (See Attached). ***4) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:*** MARS of all residents on anti-anxiety meds or perimeters will be reviewed weekly by RN Manager or her designee for three (3) months and then eight (8) random MARS will be reviewed monthly for six (6) months. The QA Committee will review the results monthly and modify the audit system after nine (9) months as the information warrants. ***5) All components of the systematic adjustments for notification of changes will be implemented***	

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	April, and May indicated the TID dose of Ativan had been given, but the one time daily extra dose ordered on an as needed basis had not been given. The clinical record lacked any social service notes related to the increase in the resident's antianxiety medication noted above on 3/7/11.. During an interview on 5/19/11 at 2:00 p.m., with Unit Manager #8, she indicated the resident was receiving Ativan due to her diagnosis of anxiety and depression. Additional information was requested related to other interventions tried prior to increasing the dose of the resident's Ativan and documentation of behavior monitoring for the week prior to and the week after the 3/7/11 medication increase. During an interview on 5/19/11 at 2:30 p.m., Unit Manager #8 indicated she was unable to provide any documentation of behaviors for the time period noted above. Additional information was requested related to behavior monitoring for the months of April and May 2011. During observations on the dates noted below, the resident was either asleep or calm. No calling out or		***by*** June 10, 2011.	

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	signs of anxiety were noted. 5/16/11 at 11:26 a.m. and 3:05 p.m. 5/17/11 an 8:10 a.m. and 10:30 p.m. 5/18/11 at 9:30 a.m. 5/19/11 at 7:10 a.m., 10:50 a.m., and 1:30 p.m. The facility failed to provide any additional information related to behavior monitoring for Resident #36 as of exit on 3/20/11. 2.) Resident #20's clinical record was reviewed on 5/18/11 at 2:30 p.m. The resident's diagnoses included, but were not limited to, anxiety and depression. The resident had current physician orders signed by the physician on 5/17/11, and included an order for lorazepam [an anxiety medication] 0.5 mg [milligrams] tablet to be given every six hours as needed for anxiety. The order failed to include signs and/or symptoms of anxiety. Review of the Medication Administration Record [MAR] for May, 2011, indicated the resident had requested and received lorazepam 0.5 mg for anxiety ten times in May. 5/18/11, 3:20 p.m., during an interview with LPN #12, she indicated the resident was aware of her			

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	medications and always knew what to ask for. On 5/19/11, 1:15 p.m., during an interview with the Director of Nursing, she indicated resident behaviors were documented on the kiosk and would indicate what symptoms Resident #20 exhibited. The Director of Nursing indicated the kiosk would contain the documentation of interventions tried before administering the lorazepam. She indicated Resident #20 had been a nurse and knew her medications. She indicated the resident will call the doctor and have discontinued medications restarted. On 5/20/11, 11:05 a.m., during and interview with LPN #7, she indicated when the resident requests lorazepam it is because the resident is shaking and nervous. She indicated she would just document increased anxiety. During an interview with RN #11 on 5/20/11 at 11:50 a.m., she indicated she had reviewed the information on the kiosk and there were no behaviors, indication for use, or interventions to try prior to administering the medication documented on the kiosk.			

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	The 5/98, Revised "Drug Therapy Policy" was provided by the Assistant Administrator on 5/20/11 at 8:30 a.m. The policy indicated "Each resident's drug regime must be free from unnecessary drugs. An unnecessary drug is any drug when used: ...(3) without adequate monitoring (4) without adequate indications for its use (6) any combination of the reasons above...." 3.) Resident #34's clinical record was reviewed on 5/18/11 at 2:44 p.m. Diagnoses for Resident #34 included, but were not limited to, chronic kidney disease, hypertension, and dysphagia. Current physician's order for Coreg 3.125 mg, one tablet, by mouth, twice a day (if pulse less than 50 beats per minute (bpm), hold and call physician). The April 2011 Medication administration record (MAR) was reviewed on 5/20/11 at 9:16 a.m. The MAR included documentation of the residents pulse 14 times during the month. The resident had 60 opportunities to receive the medication during the month and on 46 occasions the pulse was not recorded. During a 5/20/11 at 9:47 a.m., interview with LPN #10, she indicated			

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	the staff are supposed to document on the MARs any assessments, including the resident's pulse, required before medication administration. 3.1-48(a)(3) 3.1-48(a)(4)			
F0371 SS=D	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on record review, observation and interview, the facility failed to ensure 50 serving trays could be sanitized due to the surfaces having cracks, holes, and worn edges which had the potential to affect 50 residents and failed to ensure all items on room trays were covered while being transported from the food cart to the resident rooms for 6 of 11 random trays observed.	F0371	**Westminster Village Muncie, Inc. Plan of Correction F- 371 Food Procure, Store/Prepare/Serve-Sanitary** ***1) What corrective actions(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:*** A. Worn Trays - All serving trays utilized in the Health Center were replaced the day the alleged deficient practice was identified with new trays that can be properly sanitized. B. Proper Covering -	06/10/2011

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	Findings include, 1. During the tour of the service kitchen for the Healthcare Dining Room on 5-19-11 at 11:01 a.m., 50 pink serving trays had cracks, holes and/or worn, rough edges. The trays were setup as ready to use. During an interview at that time, the Dietary Manager indicated the condition of the trays is not monitored. He indicated he relies on the staff to inform him when items need replaced.		The Dietary Manager, Nutritional Services and Dietary Management staff will continue to monitor for proper coverage of all meal tray items until accepted by the resident in a desired location, i.e. resident's room. ***2) How other Residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions(s) will be taken:*** A. Worn Trays - The above mentioned serving trays found to be worn were discarded and replaced with new trays the day the alleged deficient practice was identified. Such trays will be identified through a documented auditing system conducted by Dietary Management. Dietary Management will continue to monitor and replace worn trays to ensure proper sanitizing procedures are effective. B. Proper Covering - All residents requesting a meal tray to be delivered to their unit/room have the potential to be affected by the alleged deficient practice. Dietary Management has reviewed "Tray Delivery to Unit" policy and procedures and notified both the Dietary and Nursing departments via memo to provide clarification and direction for properly distributing covered meal trays. In addition, Dietary staff will continue to be in-serviced on covering food items with emphasis on meal tray delivery and be subject to unannounced,	

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			documented meal tray audits to monitor accurate and sanitary delivery procedures. Proper tray delivery training will be included in the Nursing in-services before or on 6/10/2011. (See Attached). ***3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** A. Worn Trays - Serving trays will be of the proper condition to ensure sanitation practices are effective. Dietary management will review and revise a policy and procedure related to the above stated alleged deficient practice. Staff members will be in-serviced on proper procedures to inform Dietary management when kitchenware requires replacement. (See Attached). Dietary Management will conduct monthly audits to prevent future storage and use of worn serving trays as stated in the new policy and procedures. B. Proper Covering - Meal trays will be received by residents at their desired location under sanitary conditions in accordance with the "Tray Delivery to Unit" policy and procedures. Dietary Management has met to review, update and re-issue "Tray Delivery to Unit" policy and procedures to both the Dietary and Nursing departments. (See Attached). Dietary staff will continue to be in-serviced	

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			pertaining to properly covering food items with emphasis on meal tray delivery and be subject to unannounced, documented meal tray audits to monitor accurate and sanitary delivery procedures. Further system improvements include “Meal Cart Info” signage located on the meal cart whereas the time and proper delivery policy will be present prior to distribution. ***4) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:*** A. Worn Trays - The Dietary manager will perform an audit of all serving trays on a monthly basis for nine (9) months. The results will be reported monthly to the QA Committee by the Dietary Manager. The QA Committee will review the results monthly and modify the audit system after nine (9) months as the information warrants. (See Attached). B. Proper Covering - Meal tray audits will be conducted and evaluated by the Dietary Manager or designee for proper procedure related to loading and distribution both in the kitchen and on the units/rooms with the frequency of three (3) times per week at varying meals for an initial period of no less than thirty (30) days. Meal tray audits will then continue to be used as a QA tool following the thirty (30) days at varying	

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	155170	A. BUILDING 00 B. WING	05/20/2011

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	2.) During an observation on the Bristol Hall on 5/16/11 at 11:44 a.m., two CNA's were passing food trays on the unit to residents who were eating in their rooms. The dietary cart was parked across from the nursing station. The CNA's took the trays from the cart at the nursing station and carried them down the hallways to the resident's rooms. Four of 6 trays observed had open, uncovered food items on them. Each tray had a bowl of carrots and celery which were uncovered. Each tray also had an uncovered cookie and either an uncovered bowl of grapes or applesauce. During an observation on the Abbey Hall on 5/16/11 at 11:40 a.m., two CNA's were passing food trays on the unit to residents who were eating in their rooms. The dietary cart was parked across from the nursing station. The CNA's took the trays		times as deemed necessary based on the achievement of compliancy. Audit results will be documented and reported monthly for a period of nine (9) months through the facility's QA Committee. (See Attached). ***5) All components of the systematic adjustments for notification of changes will be implemented by*** June 10, 2011.	

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	from the cart at the nursing station and carried them down the hallways to the resident's rooms. Two of 5 trays observed had open, uncovered food items on them. One tray had an uncovered cookie and one tray had a bowl of grapes and a bowl of applesauce which were uncovered. Review of the current facility policy, titled "Tray Delivery To Unit", provided by the Assistant Administrator on 5/20/11 at 8:30 a.m., included, but was not limited to, the following: "Policy: The Dietary Department will send individual trays to the nursing units as requested by residents. The trays will be covered, transported, and held at appropriate temperatures until served. Procedure: ...2. Trays for individuals will be prepared, and covered, according to the resident's diet order and/or menu selection...." 3.1-21(i)((2) **3.1-21(i)(3)**			

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure a resident's clinical record contained accurate resident information related to a pressure area for 1 of 2 discharged residents reviewed with a pressure area in a Stage 2 sample of 25. (Resident # 79) Findings include: **Review of the current undated facility policy, titled "Clinical Record Policy" , provided by the Administrator on 5/20/11 at 2:00 p.m. indicated the following,** **" Supervising and maintaining clinical records** **Westminster Village Health Center shall maintain clinical records on each resident... The records must be as follows:**	F0514	**Westminster Village Muncie, Inc. Plan of Correction F-514 Resident Records Complete/Accurate/Accessible** ***1) What corrective actions(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:*** The closed clinical record of Resident #79 was reviewed. Confirmation of an error in documentation was noted in the resident's clinical record. ***2) How other Residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions(s) will be taken:*** All current residents with pressure ulcers clinical records have been reviewed for accuracy of proper anatomical location of pressure ulcer, assessment and Physician order and documentation to ensure they coincide. ***3) What measures will be put into place or what systemic changes will be***	06/10/2011

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	1.) Complete **2.) Accurately documented..."** **The clinical record for Resident #79 was reviewed on 5/17/11 at 3:30 p.m.** **Resident #79's current diagnoses included, but were not limited to, systolic heart failure, atrial fibrillation and dyspnea.** The clinical record for Resident #79 indicated the resident was admitted to the facility on 3/4/11 from a local hospital. An admission nursing history and physical, dated 3/4/11, indicated Resident #79 had on admission a reddened area to left heel, and an open area to the coccyx. A physician's progress note, dated 3/15/11, indicated the resident had a left heel ulcer for 1-2 weeks. A physician's order, dated 3/15/11, indicated the following order, polymen (a medicated dressing used to treat pressure ulcers) to left heel until healed, change dressing every		***made to ensure that the alleged deficient practice does not recur:*** In-services of all Nurses will be completed by June 10, 2011. In-service to include the importance of accurate documentation in medical records. (See Attached). ***4) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:*** RN Managers and QA Nurse will review pressure ulcer assessment documentation weekly for three (3) months then two (2) times a month for six (6) months. The audits will be reviewed in the Skin Committee and presented at the monthly QA Committee meeting. The QA Committee will review the results monthly and modify the audit system after nine (9) months as the information warrants. ***5) All components of the systematic adjustments for notification of changes will be implemented by*** June 10, 2011.	

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	other day. The March 2011 Medication Administration Record for Resident #79, indicated the above treatment was initiated on 3/15/11 and was documented as having been completed every other day until the resident was transferred to the hospital on 3/24/11. Review of the nursing weekly skin sheet assessment for Resident #79 indicated the following, 3/11/11 coccyx area 2 centimeters by 1 centimeter, blanchable 3/11/11 right heel .1 centimeter by .1 centimeter, reddened non blanchable 3/ 18/11 coccyx 1 centimeter by 1 centimeter, blanchable 3/18/11 right heel .1 centimeter by .1 centimeter, reddened nonblanchable The nursing weekly skin assessment for Resident #79 lacked any information related to an open area on the resident's left heel. During an interview with the Director of Nursing ,on 5/19/11 at 4:20 p.m.,she indicated the nursing staff had incorrectly written right heel on the weekly skin assessments, and the information should have been left			

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	heel. A nursing note entry, dated 3/15/11 at 2:00 p.m. indicated, new order for polymem to left heel until healed. During an interview with the Director of Nursing on 5/19/11 at 4:18 p.m., additional information was requested related to measurements the open area to the left heel. The Director of Nursing indicated, we (the facility) have a documentation issue. She indicated the left heel open area was documented incorrectly as the right heel and should have been left heel. She further indicated the error was repeated several times by different nurses. She indicated Resident #79 did not have an open area on the right heel at any time. Nursing note entries in the resident's clinical record indicated an error in documentation of the incorrect heel open area on the following dates and times, A. 3/4/11, at 2 p.m. ... "resident heel on right foot red"... B. 3/7/11, at 2 p.m. ... "note left in (Dr name) folder for tx [treatment for right heel]..." C. 3/15/11, at 9:45 a.m. ..." polymen applied to right heel"...			

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	D. 3/17/11, at 3 a.m. ..."right heel is healing"... E. 3/19/11, at 1 p.m. ..." polymen tx complete on right heel." F. 3/21/11, at 1 p.m. ... "tx changed to right heel as ordered." During an interview with the Director of Nursing on 5/20/11 at 9:30 a.m., she indicated the nursing staff had incorrectly documented right heel when it should have been left heel in the nursing notes noted above. She further indicated she had no explanation as to why the nursing staff charted incorrectly. **3.1-50(a)(2)**			

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F0520 SS=B	A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on interview, the facility Quality Assessment and Assurance Committee failed to develop and implement appropriate plans of action to address deficient practices identified during the Annual Recertification and State Licensure survey. Findings include: An interview with the Unit Manager on 5/20/11 at 8:35 A.M., indicated the facility had not identified the failure to document daily care plan	F0520	**Westminster Village Muncie, Inc. Plan of Correction F- 520 QAA Committee-Members/Meet Quarterly/Plans** ***1) What corrective actions(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:*** Appropriate QA plans have been developed for monitoring daily interventions for pressure ulcers and weight tracking. (See Attached). New kitchen serving trays were purchased and put in use during the survey process. ***2) How other Residents having the potential to be affected by the***	06/10/2011

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	interventions for a pressure ulcer for April and May as a QAA (Quality Assessment and Assurance) concern, and no action plan was developed to address this deficiency. On 5/20/11 at 9:35 A.M., an interview with the facility Administrator and the facility QAA (Quality Assurance and Assessment) nurse indicated the committee had been tracking weights for three months due to a concern brought to the committee by the nursing department, but no improvement had been noted, and the committee failed to make a change in the action plan developed to address the weight tracking concerns. The committee failed to identify worn kitchen trays needing replaced as a QAA concern, and did not develop an action plan prior to 5/17/11. 3.1-52(b)(2)		***same alleged deficient practice will be identified and what corrective actions(s) will be taken:*** QA Nurse has met with each Department Head and reviewed current reporting practices to ensure that she is aware of concerns and that they are presented to the QA Committee. ***3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** The facility QA Program has been reviewed. No changes are indicated at this time. A new Plan of Action Form for QA has been implemented to ensure compliance. (See Attached). ***4) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:*** Administration or designee will monitor and report to the QA Committee on a monthly basis the development of action plans and that appropriate follow up is in progress. The QA Committee will review the results monthly and modify the audit system after nine (9) months as the information warrants. ***5) All components of the systematic adjustments for notification of changes will be implemented by*** June 10, 2011.	